Appendix P
Colorado Medical Assistance Program
Prior Authorization Procedures and Criteria
For Physicians and Pharmacists

Drugs requiring a prior authorization are listed in this document. The Prior Authorization criteria are based on FDA approved indications, CMS approved compendia, and peer-reviewed medical literature.

Prior Authorization Request (PAR) Process

- Pharmacy PA forms are available by visiting: http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1201542571132
- PA forms can be signed by anyone who has authority under Colorado law to prescribe the medication. Assistants of authorized persons cannot sign the PA form
- Physicians or assistants who are acting as the agents of the physicians can request a PA by phone
- Pharmacists from long-term-care pharmacies and infusion pharmacy must obtain a signature from someone who is authorized to prescribe drugs before they submit PA forms
- Pharmacists from long-term-care pharmacies and infusion pharmacies can request a PA by phone if specified in the criteria
- All PA's are coded online into the PA system
- Prior Authorizations can be called or faxed to the helpdesk at:

  Phone: 1-800-365-4944

  Fax: 1-888-772-9696

- As of July 1, 2007, ICD-9 codes can be submitted in the point-of-sale system to override certain prior authorizations. To verify an ICD-9 code contact the PAR Helpdesk at:

  Phone: 1-800-365-4944

Medical Supply Items and Medications

- All supplies, including insulin needles, food supplements and diabetic supplies are not covered under the pharmacy benefit, but are covered as medical supply items through Durable Medical Equipment (DME)
- If a medical benefit requires a PA, the PA request can be submitted through the provider application available at: http://coloradopar.com/carewebqi/carewebqi-access.
- Effective March 4, 2013 all PARs and revisions processed by the Colorado PAR Program must be submitted using CWQI. After April 1, 2013, PARs submitted via fax or mail will not be entered into CWQI and subsequently not reviewed for medical necessity.
- DME questions should be directed to Xerox at: 303-534-0279 or 800-237-0757. Only policy questions regarding Durable Medical Equipment should be directed to the state at 303-866-2113.

- Medications given in a hospital, doctor's office or dialysis unit are to be billed directly by those facilities as a medical item. IV Fluids, meds, etc. may be billed by the pharmacy when given in a long-term care facility or by home infusion.

Drug	Criteria	PAR Length
ACETAMINOPHEN CONTAINING PRODUCTS	A prior authorization is required for dosages of acetaminophen containing products over 4000mg/day of acetaminophen.	N/A **Not qualified for emergency 3 day supply PA**
ACNE PRODUCTS Topical Tretinoin Products and Isotretinoin Products	Prior authorization is required for all topical tretinoin and isotretinoin products. Payment for topical tretinoin therapy and isotretinoin products will be authorized for the following diagnoses: Cystic acne, disorders of Keratinization, psoriasis, neoplasms, comedonal or acne vulgaris. ➢ *Cystic acne, disorders of Keratinization, psoriasis, or neoplasms*, do **not** require previous trials and therapy failure with other legend or non-legend anti-acne products regardless of age. Approval will be granted for a one-year period. ➢ The diagnosis of *comedonal* does **not** require previous trial and therapy failure with other legend or non-legend anti-acne products regardless of age. Approval will be granted for an initial three-month period. IF topical tretinoin therapy is effective after the initial approval period, a prior authorization will be granted for a one-year period. ➢ A diagnosis of *acne vulgaris* **requires** previous trials and treatment failures on antibiotic and /or topical treatments. If criteria are met, a prior authorization will be granted for a one-year period.	See criteria **Not qualified for emergency 3 day supply PA**
ADOXA TT AND CK KIT	A prior authorization will only be approved if a client has tried and failed on the generic oral doxycycline or topical clindamycin for a period of 3 or more months in the last 6 months. (Failure is defined as: lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions)	One year
ALBUMIN	Must have an FDA approved indication and given in the client's home or in a long-term care facility for approval. The following are FDA approved indications: ➢ Hypoproteinemia ➢ Burns ➢ Shock due to: ▪ Burns ▪ Trauma ▪ Surgery ▪ Infection ➢ Erythrocyte resuspension ➢ Acute nephrosis ➢ Renal dialysis ➢ Hyperbilirubinemia ➢ Erythroblastosis fetalis	One year

ORAL ALLERGY EXTRACT PRODUCTS	***Ragwitek (short ragweed pollen allergen extract)*** Must be between 18 and 65 years old. Must be started 12 weeks prior to the season and only prescribed seasonally. Must not be pregnant or nursing. Must be prescribed by an allergist. Must have a documented diagnosis to ONLY short ragweed pollen allergen extract or the Ambrosia family (giant, false, and western ragweed) confirmed by positive skin test or IgE antibodies. Must have tried and failed allergy shots for reasons other than needle phobia. Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction. Must be willing to administer epinephrine in case of a severe allergic reaction. Must take first dose in physician's office. Must NOT have: • Severe, unstable or uncontrolled asthma • Had an allergic reaction in the past that included trouble breathing, dizziness or fainting, rapid or weak heartbeat • Ever had difficulty with breathing due to swelling of the throat or upper airway after using any sublingual immunotherapy before • Been diagnosed with eosinophilic esophagitis • Allergic to any of the inactive ingredients contained in Ragwitek which include gelatin, mannitol, and sodium hydroxide • A medical condition that may reduce the ability to survive a serious allergic reaction including but not limited to: markedly compromised lung function, unstable angina, recent myocardial infarction, significant arrhythmia, and uncontrolled hypertension. • Taking medications that can potentiate or inhibit the effect of epinephrine including but not limited to: beta-adrenergic blockers, alpha-adrenergic blockers, ergot alkaloids, tricyclic antidepressants, levothyroxine, monoamine oxidase inhibitors, certain antihistamines, cardiac glycosides, and diuretics. • Be taken with other immunotherapy (oral or injectable) ***Grastek (Timothy grass pollen allergen extract)*** Must be between 5 and 65 years old. Must not be pregnant or nursing. Must be prescribed by an allergist. Must have a documented diagnosis to ONLY timothy grass pollen allergen extract or the Pooideae family (meadow fescue, orchard, perennial rye, Kentucky blue, and red top grasses) confirmed by positive skin test or IgE antibodies. Must have tried and failed allergy shots for reasons other than needle phobia. Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction. Must be willing to administer epinephrine in case of severe allergic reaction. Must take first dose in physician's office. Must be started 12 weeks prior to the season if giving only seasonally. May be taken daily for up to 3 consecutive years. Must NOT have: • Severe, unstable or uncontrolled asthma	One year

Drug	Criteria	PAR Length
	• Had an allergic reaction in the past that included trouble breathing, dizziness or fainting, rapid or weak heartbeat • Ever had difficulty with breathing due to swelling of the throat or upper airway after using any sublingual immunotherapy before • Been diagnosed with eosinophilic esophagitis • Allergic to any of the inactive ingredients contained in Grastek which include gelatin, mannitol, and sodium hydroxide • A medical condition that may reduce the ability to survive a serious allergic reaction including but not limited to: markedly compromised lung function, unstable angina, recent myocardial infarction, significant arrhythmia, and uncontrolled hypertension. • Taking medications that can potentiate or inhibit the effect of epinephrine including but not limited to: beta-adrenergic blockers, alpha-adrenergic blockers, ergot alkaloids, tricyclic antidepressants, levothyroxine, monoamine oxidase inhibitors, certain antihistamines, cardiac glycosides, and diuretics. • Be taken with other immunotherapy (oral or injectable) ***Oralair (Sweet Vernal, Orchard, Perennial Rye, Timothy, Kentucky Blue Grass mixed pollens allergen extract)*** Must be between 10 and 65 years old. Must not be pregnant or nursing. Must be prescribed by an allergist. Must have a documented diagnosis to ONLY Sweet Vernal, Orchard, Perennial Rye, Timothy, or Kentucky Blue Grass allergen extract confirmed by positive skin test or IgE antibodies. Must have tried and failed allergy shots for reasons other than needle phobia. Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction. Must be willing to administer epinephrine in case of severe allergic reaction. Must take first dose in physician's office. Must NOT have: • Severe, unstable or uncontrolled asthma • Had an allergic reaction in the past that included trouble breathing, dizziness or fainting, rapid or weak heartbeat • Ever had difficulty with breathing due to swelling of the throat or upper airway after using any sublingual immunotherapy before • Been diagnosed with eosinophilic esophagitis • Allergic to any of the inactive ingredients contained in Oralair which include mannitol, microcrystalline cellulose, croscarmellose sodium, colloidal anhydrous silica, magnesium stearate, and lactose monohydrate. • A medical condition that may reduce the ability to survive a serious allergic reaction including but not limited to: markedly compromised lung function, unstable angina, recent myocardial infarction, significant arrhythmia, and uncontrolled hypertension. • Taking medications that can potentiate or inhibit the effect of epinephrine including but not limited to: beta-adrenergic blockers, alpha-adrenergic blockers, ergot alkaloids, tricyclic antidepressants, levothyroxine, monoamine oxidase inhibitors, certain antihistamines, cardiac glycosides, and diuretics. • Be taken with other immunotherapy (oral or injectable)	

Drug	Criteria	PAR Length
ALPHA –1 PROTEINASE INHIBITORS Aralast, Prolastin and Zemaira	FDA approved indication if given in the client's home or in a long-term care facility: ➢ Prolastin: Emphysema associated with Alpha-1 Antitrypsin Deficiency ➢ Aralast: Chronic augmentation therapy in clients having congenital deficiency of Alpha –1 Proteinase Inhibitor with clinically evident emphysema ➢ Zemaira: Chronic augmentation and maintenance therapy in clients with Alpha- 1 Proteinase Inhibitor deficiency with clinically evident emphysema	Lifetime
ANOREXIENTS (Diet Pills)	**Not Covered**	None
ANTI-ANEMIA DRUGS (Oral and injectable drugs)	**FDA approved indication**: Iron Deficiency Anemia Injectable Drugs [i.e.: Infed (iron dextran), Venofer, Ferrlecit] ➢ Diagnosis of iron deficiency anemia when oral preparations are ineffective or cannot be used. ➢ Must be administered in a client's home or in a long-term care facility	Lifetime

Drug	Criteria	PAR Length
ATYPICAL ANTIPSYCHOTICS (**Injectable)** Abilify, Zyprexa Relprevv, Invega Sustenna, Geodon and Risperdal Consta	A prior authorization will only be approved as a pharmacy benefit when the medication is administered in a long-term care facility or in a client's home.	One year
BACTROBAN Nasal Ointment and Cream (Generic Bactroban Ointment does not require a prior authorization)	**Bactroban Cream** (mupirocin calcium cream) must be prescribed for the treatment of secondarily infected traumatic skin lesions (up to 10 cm in length or 100 cm^2 in total area), impetigo, infected eczema or folliculitis caused by susceptible strains of Staphylococcus aureus and Streptococcus pyogenes. **Bactroban Nasal Ointment** (mupirocin calcium) must be prescribed for the eradication of nasal colonization with methicillin-resistant Staphylococcus aureus in adult patients and health care workers as part of a comprehensive infection control program to reduce the risk of infection among patients at high risk of methicillin-resistant S. aureus infection during institutional outbreaks of infections with this pathogen.	Cream: One year Nasal Ointment: Lifetime
BELVIQ (lorcaserin)	Weight loss drugs are not a covered benefit.	
BENLYSTA (belimumab)	A prior authorization may be approved only when documentation has been received indicating that the drug is being administered in the client's home or long-term care facility. The client must also meet the following criteria: • Diagnosis of autoantibody postitive SLE with organ involvement; AND • Incomplete response to standard therapy from at least two of the following therapeutic classes: antimalarials, immunosuppressants and glucocorticoids; AND • Maintenance of standard therapy while on BENLYSTA.	One year
BARBITURATES	Barbiturates will require prior authorization for all Medicaid clients. Beginning on January 1, 2013, the Colorado Medicaid Program will no longer be allowed to cover barbiturates for Medicare-Medicaid enrollees (dual-eligible clients) if they are to be used in the treatment of epilepsy, cancer, or a chronic mental health disorder. Prior authorization will be approved for dual-eligible clients for use in sedation, treatment of insomnia, tension headache, muscle contraction headache and treatment of raised intracranial pressure. All other uses will require manual review. For Medicaid primary clients, barbiturates will be approved for use in epilepsy, cancer, chronic mental health disorder, sedation, treatment of insomnia, tension headache, muscle contraction headache and treatment of raised intracranial pressure. All other uses will require manual review.	One year
BENZODIAZEPINES	Benzodiazepines will no longer be a Medicaid benefit for Medicare-Medicaid enrollees (dual-eligible clients). The claims are no longer excluded from Medicare part D coverage, and thus must be billed to Medicare part D. The Colorado Medicaid Program will no longer be allowed to cover these medications beginning on January 1, 2013. Coverage will remain in effect for Medicaid primary clients.	One year

Drug	Criteria	PAR Length
BISPHOSPHONATES (Injectable) Didronel, Boniva, Aredia, Miacalcin, Zemplar, Hectorol, Zometa, Pamidronate, and Ganite	A prior authorization will only be approved as a pharmacy benefit when the medication is administered in a long-term care facility or in a client's home.	One year **Not qualified for emergency 3 day supply PA**
BLOOD PRODUCTS	FDA approved indications if given in the client's home or in a long-term care facility: ➢ Plasma protein fraction; shock due to burns, trauma, surgery; hypoproteinemia; adult respiratory distress syndrome; cardiopulmonary bypass; liver failure; renal dialysis; or hemophilia.	Lifetime
BOTOX / MYOBLOC INJECTION	FDA approved indication if given in the client's home or in a long-term care facility. ➢ *Cervical or Facial Dystonia* ***Not approved for Cosmetic Purposes***	One year
BRAND NAME MEDICATIONS	Only brand name drugs that have a generically equivalent drug (as determined by the FDA) require a prior authorization. Exceptions to the rule include: ➢ The brand name drug has been exempted (see the list below) ➢ When the reimbursement for a brand-name drug is less expensive than the cost of the generic equivalent ➢ The physician is of an opinion that a transition to the generic equivalent of a brand-name drug would be unacceptably disruptive to the patient's stabilized drug regimen ➢ The patient is started on a generic drug but is unable to continue treatment on the generic drug as determined by the patient's physician The following list of drug classes is exempt from the generic mandate rule (no PA is required). Medications used for the treatment of: ➢ Biologically based mental illness defined in 10-16-104 (5.5) C.R.S. ➢ Cancer ➢ Epilepsy ➢ HIV/AIDS	One year
CIALIS (tadalafil)	Cialis will be approved for clients with a documented diagnosis of BPH who have failed a trial of finasteride (at least 3 months in duration) AND either a trial of a nonselective alpha blocker (therapeutic dose for at least two months) OR a trial of tamsulosin (therapeutic dose for at least one month). Documentation of BPH diagnosis will require BOTH of the following: 1. AUA Prostate Symptom Score ≥ 8 AND 2. Results of a digital rectal exam. Cialis will not be approved for any patient continuing alpha-blocker therapy as this combination is contraindicated in this population. Doses exceeding 5mg per day of Cialis will not be approved.	One year

Drug	Criteria	PAR Length
CITALOPRAM (high dose)	Prior authorization will be required for doses exceeding 40mg/day. Please see the FDA guidance at: http://fda.gov/Drugs/DrugSafety/ucm269086.htm for important safety information.	One year
COLCRYS (colchicine)	Quantity Limits: • Chronic hyperuricemia/gout prophylaxis: 60 tables per 30 days • Familial Mediterranean Fever:120 tablets per 30 days	One year
COUGH AND COLD (Rx)	Client <21 years: covered benefit. A prior authorization is not needed. Client ≥ 21 years must have diagnosis of a chronic condition such as COPD or asthma.	One year

<table>
<tr><th>Drug</th><th>Criteria</th><th>PAR Length</th></tr>
<tr><td>COX-2 INHIBITORS

Celebrex</td><td>PA is required for clients who are 64 years of age and younger. Clients over the age of 65 do not require a PA.
A PA will be approved if the COX-2 is prescribed for a FDA approved indication.
<table>
<tr><td>FDA Approved Indication</td><td>Dose and Length of PA</td></tr>
<tr><td>Acute Pain</td><td>Up to 600mg day 1; 200mg BID for no more than 30 days</td></tr>
<tr><td>Dysmenorrhea</td><td>Up to 600mg day 1; 200mg BID. One year approval</td></tr>
<tr><td>Ankylosing spondylitis</td><td>200mg daily; after 6 weeks of 200mg daily dosing if client’s condition has been unresponsive, 400mg daily may be approved. Lifetime approval</td></tr>
<tr><td>Familial Adenomatous Polyposis</td><td>400mg BID. Lifetime approval</td></tr>
<tr><td>Osteoarthritis</td><td>200mg daily; 100mg BID. Lifetime approval</td></tr>
<tr><td>Rheumatoid Arthritis</td><td>100-200mg BID. Lifetime approval</td></tr>
<tr><td>Juvenile Rheumatoid Arthritis</td><td>Up to 100mg BID. 6 month approval</td></tr>
</table></td><td>See chart</td></tr>
<tr><td>DEPO PROVERA / LUNELLE</td><td>FDA approved indication if given in a long-term care facility or in the clients home:
➢ Females: Contraception, uterine bleeding, amenorrhea, endometrial cancer
➢ Males: Sexual aggression / Pedophilia – Only Depo-Provera will be approved

Not approved for administration in the physician’s office – these must be billed through medical.</td><td>One year</td></tr>
<tr><td>DESI DRUGS</td><td>DESI drugs (Drugs designated by the Food and Drug Administration as Less Than Effective Drug Efficacy Study Implementation medications) are not a covered benefit.</td><td></td></tr>
</table>

Drug	Criteria	PAR Length
DIFICID	Dificid will be approved if all the following criteria are met: • The indicated diagnosis (including any applicable labs and/or tests) and medication usage must be supported by documentation from the patient's medical records AND • Prescriber must be a gastroenterologist or an infectious disease specialist AND • Diagnosed with Clostridium difficile-associated diarrhea AND • ≥ 18years of age AND • Failed at least a 10 day treatment course with oral metronidazole AND oral vancomycin OR • Allergy and/or intolerance to both metronidazole and vancomycin Quantity limits: Dificid: Max 20 tabs/30 days	10 days
ELESTRIN GEL	A prior authorization will only be approved if a client has tried and failed on generic oral estradiol therapy and diagnosed with moderate-to-severe vasomotor symptoms (hot flashes) associated with menopause. (Failure is defined as: lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions)	One year
EPANED	Epaned will be approved for clients under the age of 5 years who cannot swallow a whole or crushed tablet.	One year
ERECTILE DYSFUNCTION DRUGS Caverject Cialis Edex Levitra Muse Viagra	These drugs are not a covered benefit. --- Yohimbine: PAs can no longer be approved for erectile dysfunction. Any PAs for use as a mydriatic agent or a vasodilator (not related to erectile dysfunction) may be approved.	Not available **Not qualified for emergency 3 day supply PA** --- Lifetime

Drug	Criteria	PAR Length
FENTANYL PREPARATIONS Actiq, Fentora, Onsolis and Duragesic Transdermal System	Actiq, Fentora and Onsolis: Approval will be granted if the client is diagnosed with cancer and has already received and is tolerant to opioid drugs for the cancer pain. The PA may be granted for up to 4 lozenges, tablets or soluble films per day. Duragesic Transdermal System: A PA is required for doses of more than 1 Patch/2 Days. For all Fentanyl preparations: If the patient is in hospice, the PA will be automatically granted regardless of the number of doses prescribed.	One year
FLECTOR 1.3% PATCH	A prior authorization will only be approved if a client has tried and failed on Voltaren Gel. (Failure is defined as: lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions)	One year
FLUORIDE PREPARATIONS	A prior authorization will not be needed for clients less than 21 years of age. Prior authorization requests for clients 21 years of age and older will be individually reviewed by the state.	N/A

Drug	Criteria	PAR Length
FILGRASTIM/ PEGFILGRASTIM / SARGRAMOSTIM Neupogen, Neulasta and Leukine	Prior authorization is required for therapy with filgrastim, pegfilgrastim or sargramostim. **Prior authorizations for PEGFILGRASTIM will be approved for the following indication if the criterion is met:** Indication: To decrease the incidence of infection due to neutropenia in clients receiving myelosuppresive anti-cancer therapy. ➢ Criterion 1. CBC and platelet count obtained before chemotherapy is administered. **Prior authorizations will be approved for FILGRASTIM AND SARGRAMOSTIM for the following indications if the applicable criteria are met:** Indication: To decrease the incidence of infection due to severe neutropenia caused by myelosuppresive anti-cancer therapy. ➢ Criterion 1. Either the post nadir ANC is less than 10,000 cells/mm^3 or the risk of neutropenia for the client is calculated to be greater than 20% ➢ Criterion 2. Routine CBC and platelet counts twice weekly Indication: Use in patients undergoing bone marrow transplant and for use after bone marrow transplant. ➢ Criterion 1. Routine CBC and platelet counts at least three times weekly for filgrastim and two times weekly for sargramostim. Indication: For patients undergoing peripheral blood progenitor cell collection and therapy. ➢ Criterion 1. Monitoring of neutrophil counts after four days of treatment. Indication: For filgrastim only, for chronic administration to reduce the incidence and duration of clients with congenital neutropenia, cyclic neutropenia or idiopathic neutropenia. ➢ Criterion 1. CBC and platelet count obtained before treatment with filgrastim begins. ➢ Criterion 2. Routine CBC and platelet counts twice weekly during initial four weeks of therapy and during the two weeks following any dose adjustment. Indication: To decrease the incidence of infection due to severe neutropenia in HIV/AIDS clients. ➢ Criterion 1. Evidence of neutropenia Infection exists or ANC is below 750 cells/mm^3 ➢ Criterion 2. ANC is maintained at Approximately 1,000 cells/mm^3 by filgrastim adjustment ➢ Criterion 3. Routine CBC and platelet counts as needed.	One year

Drug	Criteria	PAR Length
FUZEON	If administered in the physician's office or delivered to physician's office, physician must bill as a medical claim on the 1500 claim form **(no PA required).** If administered in the client's home or in a long-term care facility, a prior authorization is required and must meet the criteria below for approval Based on clinical trial data, ENF should be used as part of an *optimized* background regimen for treatment-experienced clients: ➢ For treatment-experienced clients with evidence of HIV-1 replication, treatment should include at least one antiretroviral agent with demonstrated HIV-1 susceptibility on the basis of genotypic/phenotypic *resistance* assays, and *two* "active" antiretroviral agents. o Clients must have limited treatment options among currently commercially available agents. ➢ Clients must be 18 years of age or older with advanced HIV-1 infection, and not responding to approved antiretroviral therapy. ➢ Clients must have a CD4 lymphocyte count less than 100 cells/mm3 and a viral load greater than 10,000 copies/ml (measurement within the last 90 days). Past adherence must be demonstrated based on: ➢ Attendance at scheduled appointments, and/or ➢ Prior antiretroviral regimen adherence, and/or ➢ Utilization data from pharmacy showing client's use of medications as prescribed ➢ Ability to reconstitute and self-administer ENF therapy. At 24 weeks, clients must experience at least ≥ 1 $\log_{10}$ decrease in HIV RNA or have HIV RNA below quantifiable limits to continue treatment with ENF. Clients are not eligible if antiretroviral treatment-naive and/or infected with HIV-2. Pre-approval is necessary Practitioner must either be Board Certified in Infectious Disease, or be an HIV experienced practitioner. Verification must be produced with the prior approval documents. **These guidelines may be modified on the basis of other payer formularies and/or the emergence of new data.**	Six months
GATTEX (teduglutide)	Prior authorization will be approved if all of the following criteria are met: • Client is 18 years of age or older; • Client has documented short bowel syndrome; • Client is dependent on parenteral nutrition for twelve consecutive months; • The prescribing physician is a gastroenterologist; and	Two months initially; may be approved by State for up to one year

Drug	Criteria	PAR Length
	• Medical necessity documentation has been received and approved by Colorado Medicaid clinical staff (please fax to 303-866-3590 attn: Clinical Pharmacy Staff) • The initial prior authorization will be limited to a two month supply.	
H2 BLOCKERS **Ranitidine capsules and liquid**	**Generic H2 Blockers** do not require a PA except for ranitidine capsules and liquid. Ranitidine capsules: Require the prescribing provider to certify that capsules are "medically necessary" and that the client cannot use the tablets. Ranitidine liquid: A prior authorization will be granted for clients with a feeding tube or who have difficulty swallowing. A prior authorization is not required for children under 12 years of age.	One year
Hetlioz (tasimelteon)	HETLIOZ® will be approved for clients who meet the following criteria: • Have a documented diagnosis of non-24-hour sleep wake disorder (non-24 or N24) by a sleep specialist AND • Client is completely blind	One year
HORIZANT (gabapentil enacarbil)	A prior authorization may be approved for clients meeting all of the following criteria: • Diagnosis of Restless Leg Syndrome; • Therapy failure on at least a one month trial of Mirapex (pramipexole) and Requip (ropirinole); • Incomplete therapeutic response to generic gabapentin. A maximum of one tablet per day will be approved.	One year
IMPLANON	See PHYSICIAN ADMINISTERED DRUGS. Not a covered pharmacy benefit when implanted in the clinic or hospital outpatient center.	
IVIG	Clients must have one of the following conditions: ➢ Immunodeficiency disorders: 1. Common Variable Immunodeficiency (CVID) 2. Severe Combined Immunodeficiency (SCID) 3. X-Linked Agammaglobulinemia 4. X-Linked with Hyperimmunoglobulin M (IgM) Immunodeficiency 5. Wiskott-Aldrich Syndrome 6. Pediatric Human Immunodeficiency Virus (HIV): ▪ Clients are less than 13 years of age and CD-4 Count is > 200/mm3 ➢ Neurological disorders: 1. Guillain-Barre' Syndrome 2.Relapsing-Remitting Multiple Sclerosis 3. Chronic Inflammatory Demyelinating Polyneuropathy 4.Myasthenia Gravis 5.Polymyositis and Dermatomyositis ➢ Chronic Lymphocytic Leukemia (CLL) ➢ Autoimmune Neutropenia (AN): 1.Absolute neutrophil count is less than 800 mm	One year One year CLL: One year AN: 6 months

Drug	Criteria	PAR Length
	And 2.Has recurrent bacterial infections ➢ Autoimmune Hemolytic Anemia (AHA) ➢ Liver or Intestinal Transplant ➢ Idiopathic Thrombocytopenic Purpura (ITP): 1. Preoperatively for clients undergoing elective spleenectomy with platelet count < 20,000 2. Clients with active bleeding & platelet count <30,000. 3. Pregnant women with platelet counts <10,000 in the third trimester. 4. Pregnant women with platelet count 10,000 to 30,000 who are bleeding.	AHA: 5 weeks ITP: 5 days
JUXTAPID (lomitapide)	Prior authorization will be approved if all of the following criteria are met: • Client is 18 years of age or older; • Client has documented diagnosis of homozygous familial hypercholesterolemia (HoFH); • Client has failed therapy with high dose statin therapy (e.g. atorvastatin 40mg or higher, Crestor 20mg or higher) • The prescribing physician is enrolled in the Juxtapid REMS program.	One year
KALYDECO	Kalydeco will only be approved if all of the following criteria are met: 1. Client has been diagnosed with cystic fibrosis AND 2. Client is an adult or pediatric patient 6 years of age or older AND 3. Documentation has been provided to indicate a G551D mutation in the CFTR gene AND 4. Documentation has been provided that baseline ALT and AST have been accessed and are within 2x normal limits (AST and ALT should be examined every 3 months for the first year and annually after that). Kalydeco will only be approved at doses no more than 150 mg twice daily. Prior Authorizations need to be obtained yearly. Kalydeco will not be approved for clients who are concurrently receiving rifampin, rifabutin, phenobarbital, carbamazepine, phenytoin, or St. John's Wort.	One year
KYNAMRO	Kynamro will be approved for clients meeting all of the following criteria: • Confirmed diagnosis of homozygous familial hypercholesterolemia (HoFH) as determined by either a or b a. Laboratory tests confirming diagnosis of HoFH: LDLR DNA Sequence Analysis OR LDLR Deletion/Duplication Analysis for large gene rearrangement testing---only if the Sequence Analysis is negative OR APOB and dPCSK9 testing if both of the above tests are negative but a strong clinical picture exists.	

Drug	Criteria	PAR Length
	b. Documentation is received confirming a clinical or laboratory diagnosis of HoFH • Has a history of therapeutic failure, contraindication, or intolerance to high dose statin therapy or cholesterol absorption inhibitor (ezetimibe or bile acid resin) AND • Is being prescribed by a physician specializing in metabolic lipid disorders AND • The prescriber is enrolled in the REMS program AND • Is not being used as monotherapy AND • Has baseline liver function (AST,ALT, ALK,, and total bilirubin) AND • Does not have moderate or severe hepatic impairment or active liver disease.	
LIPIDS/AMINO ACIDS/PLASMA PROTEINS	Approval will be given if administered in the client's home or in a long-term care facility. If given in the hospital or physician's office, the claim must be billed as a medical expense.	Lifetime
LHRH/GnRH Luteinizing Hormone Releasing Hormone/Gonadtropin Releasing Hormone	Must be given in the client's home or in a long-term care facility. Prior authorization will be granted for FDA Approved Indications Only: ➢ **Lupron (leuprolide):** Prostate Cancer, Endometriosis, Uterine Leiomyomata (fibroids), Precocious Puberty ➢ **Zoladex**: Breast Cancer, Endometriosis, Endometrial Thinning, Prostate Cancer ➢ **Trelstar**: Palliative treatment of Advanced Prostate Cancer ➢ **Eligard:** Palliative-treatment of Advanced Prostate Cancer ➢ **Viadur:** Palliative treatment of Advanced Prostate Cancer ➢ **Vantas**: Palliative treatment of Advanced Prostate Cancer	One year
LYRICA pregabalin	For clients with no epilepsy diagnosis in the last two years (as confirmed by SMART PA), Prior Authorization will be required for LYRICA prescriptions requiring more than 3 capsules per day or for prescriptions requiring doses greater than 600mg per day.	One year

Drug	Criteria	PAR Length
MAKENA Hydroxyprogesterone caproate injection	Makena will be approved for clients that meet the following criteria • The drug is being administered in the home or in long-term care setting; • Client has a Singleton pregnancy and a history of singleton spontaneous preterm birth; • Therapy is being initiated between 16 weeks gestation and 20 weeks, 6 days gestation. • Dose is administered by a healthcare professional; • Compounded hydroxyprogesterone product is contraindicated.	
MOXATAG	A prior authorization will only be approved if a client is allergic to inactive ingredients in immediate release amoxicillin.	One year
NEWLY APPROVED PRODUCTS	Newly marketed drugs may be subject to prior authorization for a minimum of nine months following FDA marketing approval. Initial approval criteria will include non-preferred criteria (for drugs within a reviewed PDL class); or FDA approved indications, dose, age and place in therapy. For drugs in PDL classes, the next class annual review will include the new agent. For non-PDL drugs, criteria shall be reviewed at the quarterly DUR meeting closest to the nine month minimum.	One year
NEXPLANON	See PHYSICIAN ADMINISTERED DRUGS. Not a covered pharmacy benefit when implanted in the clinic or hospital outpatient center.	
ORACEA	A prior authorization will only be approved if all of the following criteria are met: ➢ client has taken generic doxycycline for a minimum of three months and failed therapy in the last 6 months (Failure is defined as: lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions), ➢ client has been diagnosed with rosacea with inflammatory lesions, and ➢ client is 18 years of age or older	16 weeks

Drug	Criteria	PAR Length
OTC PRODUCTS	Medical Necessity ➢ Aspirin, Insulin and Plan B are covered without a PA ➢ Prilosec OTC: *See Proton Pump Inhibitor's section* ➢ Guaifenesin 600mg LA is covered for clients having an abnormal amount of sputum ➢ Quinine Sulfate *is no longer covered* for leg cramps ➢ Herbal products are not a benefit except for cranberry tablets, which are covered for urinary tract infections ➢ Diabetic needles and supplies are not a prescription benefit and should be billed as supply ➢ Broncho saline is not covered- refer to Sodium Chloride section ➢ Cough and Cold Products must have a diagnosis of a chronic respiratory condition for which these medications may be prescribed or otherwise be medically necessary ➢ Antihistamine (w/ decongestant) must have a diagnosis of seasonal or perennial allergic rhinitis or chronic sinusitis or otherwise be medically necessary ➢ Nicomide is approved for acne *Nursing Facilities: Please provide OTC floor stock list.* *Clients with Erythema Bullosum (EB) can receive any OTC medication with a prior authorization.*	One year **Qualifies for emergency 3 day supply PA**
Otezla (apremilast)	OTEZLA® will be approved for clients who meet the following criteria: • Client is ≥ 18 years of age AND • Is not receiving rifampin, phenobarbital, carbamazepine, or phenytoin AND • Client does not have severe renal impairment (Crcl< 30 ml/min) AND • Has failed a 12 week trial of two of the following: leflunamide, methotrexate, sulfasalazine, and cyclosporine AND a 12 week trial of either ENBREL or HUMIRA. Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interactions	One year
OXSORALEN	Approval will be granted with diagnosis of: Myosis; Fungoides; Psoriasis or Vitiligo	One year

Drug	Criteria	PAR Length
PHYSICIAN ADMINISTERED DRUGS	Medications given in a hospital, doctor's office or dialysis unit are only to be billed directly by those facilities as a medical item. IV Fluids, meds, etc. may be billed by the pharmacy when given in a long-term care facility or by home infusion following prior authorization approval. Prior authorizations will be approved based upon documentation of the location for administration.	
PROCYSBI	Approval will be granted if the client is 6 years of age or older **AND** Has a diagnosis of neuropathic cystinosis **AND** documentation is provided to the Department that treatment with cysteamine IR (Cystagon®) was ineffective, not tolerated, or is contraindicated.	One year
PROMETHAZINE	A Prior authorization is required for all routes of administration for clients under the age of two. Children under the age of two should not use Promethazine. Promethazine is contraindicated in such patients because of the potential for fatal respiratory depression.	One year **Not qualified for emergency 3 day supply PA**
PROPECIA	***Not covered for hair loss***	One year **Not qualified for emergency 3 day supply PA**
QSYMIA (phentermine/topiramate ER)	Weight loss drugs are not a covered benefit.	
RAVICTI (glycerol phenylbutyrate)	Raviciti will only be approved for clients meeting the following criteria: • Client must be 2 years of age or older • Client must have a documented diagnosis of urea cycle disorder (UCD) • Client must be on a dietary protein restriction (verified by supporting documentation) • Client must have tried and failed Buphenyl as evidenced by uncontrolled hyperammonia over the past 365 days • Medication must be prescribed by a physician experienced in the management of UCD (e.g., geneticist)	One year
REBATE DISPUTE DRUGS	Medical necessity.	One year **Not qualified for emergency 3 day supply PA**
REQUIP XL	A prior authorization will only be approved if a client has tried and failed on generic immediate release ropinirole for a period of 3 or more months in the last 6 months and the client has a diagnosis of Parkinson's disease. (Failure is defined as: lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions) **Grandfathering:**	One year

Drug	Criteria	PAR Length
	Clients who have been previously stabilized on Requip XL can receive approval to continue on the medication for one year if medically necessary.	
REVIA/NALTREXONE	A PA is no longer required.	N/A
RYBIX ODT	Rybix will be approved for clients who are unable to swallow oral tablets or for clients who are unable to absorb oral medications.	One year
RYZOLT	A prior authorization will only be approved if a client has tried and failed on the maximum dose of tramadol (400mg per day) for a period of 3 or more months in the last six months. (Failure is defined as: lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions)	One year
SANDOSTATIN	Approved for: acromegaly; carcinoid tumors; and vasoactive intestinal peptide tumors.	Lifetime
SEROQUEL (quetiapine) at doses < 150mg/day	Low-dose quetiapine (<150mg/day) is only FDA approved as part of a drug titration schedule to aid patients in getting to the target quetiapine dose. Prior authorization will be required for quetiapine < 150mg per day for longer than 30 days, except for utilization (when appropriate) in clients age 65 years or older.	One year
SILENOR	A prior authorization will be approved if a client meets one of the following criteria: • Contraindication to preferred oral sedative hypnotics (Lunesta, zaleplon and zolpidem) • Medical necessity for doxepin dose < 10 mg • Age greater than 65 years old or hepatic impairment (3 mg dose will be approved if this criteria is met)	One year
SIMVASTATIN 80mg	Simvastatin 80mg dose products will only be covered for clients who have been stable for more than 12 months at that dose. Providers should consider alternate preferred statins in clients who have not met cholesterol goals on simvastatin at doses up to 40mg per day. Please refer to the FDA communication entitled, "FDA Drug Safety Communication: New restrictions, contraindications, and dose limitations for Zocor (simvastatin) to reduce the risk of muscle injury" for updated guidance on contraindications, dose limits and relative LDL lowering doses of alternatives.	One year
SMOKING CESSATION (Rx & OTC)	Clients should be referred to the QuitLine or another behavior modification program. The name of that program should be included on the prior authorization form. Medical Assistance Program will pay for only **one product** at a time but a client may receive multiple strengths of a product or multiple products during the two 90-day paid benefit periods.	Two 90-day paid benefits per year **Not qualified for emergency 3 day supply PA**
SODIUM CHLORIDE For inhalation use	Broncho Saline is **not** covered as a drug benefit. **Sodium Chloride 0.9%:** Only the 3cc unit dose is covered, if the client is sight-impaired and used in the client's home. **Sodium Chloride 3% and 7% vial:** Nebulizer treatment for clients with cystic fibrosis and other pulmonary diseases for mucolytic therapy done in the home.	Lifetime **Qualifies for emergency 3 day supply PA**

Drug	Criteria	PAR Length
	All other requests for sodium chloride (inhalation use) must be billed through medical.	
SOLARAZE 3% GEL	A prior authorization will only be approved if the client has a diagnosis of Actinic Keratoses (AK).	One year
SUBOXONE and SUBUTEX	Suboxone will be approved if the following criteria are met: ➢ The prescriber is authorized by the manufacturer to prescribe Suboxone ➢ The client has an opioid dependency ➢ The client is not currently receiving an opioid or opioid combination product. ★Suboxone will not be approved for the treatment of pain. ★Opioid claims will not be allowed for clients with a claim for Suboxone in the preceding 30 days. ★Suboxone will not be approved for more than 24mg of buprenorphine /day Subutex will be approved if all of the following criteria are met: ➢ The prescriber is authorized by the manufacturer to prescribe Subutex ➢ The client has an opioid dependency ➢ The client is pregnant or the client is allergic to Naloxone ★Subutex will not be approved for the treatment of pain. ★Subutex will not be approved for more than 24mg/day	One year

SYNAGIS	**PharmacyPrior Authorization requests for Synagis must be submitted by fax or phone using the Synagis Prior Authorization Form found at http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1201542696550. Medical PAs must be submitted through coloradopar.com.** **A Prior Authorization can be approved if:** The medication will be administered in the client's home; the client is under age 2 at the start of the current RSV season (as determined by the CDC); and who meets one of the following: 1. Diagnosis of Chronic Lung Disease (CLD) AND having one or more of the following clinical needs in the previous 6 months: a. Supplemental oxygen; b. Regular use of inhaled or oral bronchodilators; c. Recent use of corticosteroid therapy; or d. Regular or intermittent use of diuretics to treat pulmonary disease. ***Up to five (5) monthly doses will be approved.** 2. Diagnosis of Interstitial Lung Disease and/or Neuromuscular disease which impacts pulmonary function *** Up to five (5) monthly doses will be approved.** 3. Any infant or child under the age of 2 who has a diagnosis of congenital heart disease and meets any of the following criteria: a. Receiving medication to control congestive heart failure (diuretics, antihypertensives); b. Suffer moderate to severe pulmonary hypertension; or c. Suffer Cyanotic Heart Disease. *** Up to five (5) monthly doses will be approved.** 4. Any infant up to 6 months of age, born 29 to less than 32 weeks gestation *** Up to five (5) monthly doses will be approved.** 5. Any infant up to 12 months of age, born at 28 weeks or less gestation *** Up to five (5) monthly doses will be approved.** 6. Any infant younger than 3 months of age at the start of the RSV season, born at 32 to less than 35 weeks gestation and meets one of the following risk factors: a. Currently attends day care; b. Has a sibling younger than 5 years of age; c. Congenital abnormalities of the airway; or d. A neuromuscular condition that compromises handling of respiratory secretions. ***Up to three (3) monthly doses will be approved or until the child reaches 3 months of age.** 7. Infants up to 2 years of age with hemodynamically significant heart disease defined as having one or more of the following: a. Infants receiving medication to control congestive heart failure; b. Infants with moderate to severe pulmonary hypertension; or c. Infants with cyanotic heart disease. *** Up to five (5) monthly doses will be approved.**	See individual approval criteria

Drug	Criteria	PAR Length
TARGETED IMMUNE MODULATORS FOR RA (iv infused products)	Remicade (infliximab) will be approved for clients who are receiving the infusion in their home or in long-term care and who meet one of the following: ➢ clients with ulcerative colitis ➢ clients with rheumatoid arthritis who have tried and failed therapy with both Enbrel and Humira ➢ clients with psoriatic arthritis ➢ clients with ankylosing spondylitis ➢ clients with juvenile idiopathic arthritis ➢ clients with plaque psoriasis ➢ clients with Crohn's Disease Orencia (abatacept) – will be approved for clients who are receiving the infusion in their home or in long-term care and who meet one of the following: ➢ Clients with moderate to severe rheumatoid arthritis who have failed therapy with both Enbrel and Humira ➢ Clients with moderate to severe juvenile idiopathic arthritis Rituxan (rituximab) - will be approved for clients who are receiving the infusion in their home or in long-term care and who meet one of the following: ➢ Clients with moderate to severe rheumatoid arthritis who have tried and failed both Enbrel and Humira ➢ Clients with Chronic Lymphocytic Leukemia ➢ Clients with Non-Hodgkins Lymphoma	One year
THROMBOLYTIC ENZYMES	Approved for **IV Catheter Clearance or Occluded AV Cannula** if given in client's home or long term care facility.	One year
TPN PRODUCTS	Approval will be given if administered in the client's home or in a long-term care facility. If given in the hospital or physician's office, the claim must be billed as a medical expense.	Lifetime
TRAMADOL	Tramadol is not approved for more than 400mg/day.	N/A **Not qualified for emergency 3 day supply PA**

Drug	Criteria	PAR Length
ULTRAM ER	A prior authorization will only be approved if a client has tried and failed on the maximum dose of tramadol (400mg per day) for a period of 3 or more months in the last six months. (Failure is defined as: lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions)	One year
VACCINES Flu, Hepatitis B and Pneumonia	H1N1 vaccine is a covered benefit. All other vaccines must be bill on Colorado 1500 form as a medical expense unless administered in long-term care facility. Any vaccine can be approved by prior authorization if a client is living in a long-term care facility. (Not a covered benefit for regular patients – only long-term care facilities).	One year **Not qualified for emergency 3 day supply PA**
VERIPRED	A prior authorization will only be approved if a client has tried and failed on a generic prednisolone product. (Failure is defined as: lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions)	One year
VERSED Midazolam	Approved if given in the client's home or in a long-term care facility and given for: ➢ Preoperative sedation or anesthesia ➢ Terminally ill clients with Cancer ➢ Client with Erythema Bullosum (EB) –approval for one year	One month
VERSED Midazolam injection used as nasal spray	Midazolam injection used as a nasal inhalation will be approved for clients who meet the following criteria: 1. Client is ≥ 6 months of age AND 2. Has a diagnosis of seizure disorder AND 3. Is prescribed by or in conjunction with a Neurologist AND 4. Treatment dose does not exceed 10mg Dosing Limits: 10 vials/month Only MIDAZOLAM 5mg/ml (for doses ≤ 5mg) and 10mg/2ml vials (for doses > 5 mg) will be covered.	One year
VIMOVO	Approved if client has failed treatment with two Preferred Proton Pump Inhibitors within the last 24 months, and has one of the following diagnoses: ➢ Ankylosing spondylitis in patients at increased risk of developing NSAID induced ulcers; ➢ Osteoarthritis in patients at increased risk of developing NSAID induced ulcers; ➢ Rheumatoid arthritis in patients at increased risk of developing NSAID induced ulcers.	One year

Drug	Criteria	PAR Length
VITAMINS (Rx)	**Prescription Vitamins (except for prenatals) will be authorized for:** ➢ ESRD, CRF, renal insufficiency, diabetic neuropathy or renal transplant ➢ Clients under the age of 21 with a diagnosis disease that prohibits the nutrition absorption process as a secondary effect of the disease. ➢ Clients with Erythema Bullosum (EB) (continued on next page) **Hydroxocobalamin Injections** In addition to the above general vitamin criteria, approval can also be given for methylmalonic academia (MMA). **Cyanocobalamin Injections** In addition to the above general vitamin criteria, approval can also be given for vitamin B12 deficiency. **Folic Acid Vitamins (exceptions exist for Folic Acid 1mg, see below)** In addition to the above general vitamin criteria, approval can also be given for folic acid vitamins if one of the following criteria is met: ➢ Currently taking Methotrexate or Alimta ➢ A diagnosis of folic acid deficiency (megaloblastic and macrocytic anemia are the most common). Some drugs or other conditions may cause deficiency -- Approval will be granted for these indications IF the client has current folic acid deficiency and documented by the provider. ➢ **For Female Clients:** Approval will be granted for the prevention of a neural tube defect pregnancy and for the prevention of miscarriages. ➢ Homocysteinemia ➢ Sickle cell disease **Cyanocobalamin/Folic Acid/Pyridoxine** In addition to the above general vitamin criteria, approval can also be given for clients: ➢ with Homocysteinemia or Homocystinuria ➢ on dialysis ➢ with or at risk for cardiovascular disease **Deplin** approved for depressed clients who are currently taking antidepressants and are partial or non-responders **Metanx** approved for clients with non-healing diabetic wounds **Prenatal Vitamins are a regular benefit for all female clients. Prenatal vitamins are not covered for male clients.** **Folic Acid 1mg does not require a prior authorization for female clients.** **Prescription Vitamin D and Vitamin K products do not require a prior authorization.**	One year **Qualifies for emergency 3 day supply PA**

Drug	Criteria	PAR Length
VIVITROL	Approval will be given if administered in the client's home or in a long-term care facility. If given in the hospital or physician's office, the claim must be billed as a medical expense.	One year **Not qualified for emergency 3 day supply PA**
VUSION OINTMENT	A prior authorization will only be approved if a client has failed on an OTC antifungal **and** a generic prescription antifungal. (Failure is defined as: lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions)	One year
XENICAL	Xenical is not covered.	N/A
XOLAIR	A prior authorization will only be approved as a pharmacy benefit when the medication is administered in a long-term care facility. Medications administered in a physician's office must be billed as a medical expense. Because this medication has a Black Box warning requiring the administration under the supervision of a physician, a PA will not be approved if administered in a client's home.	One year **Qualifies for emergency 3 day supply PA**
ZUBSOLV	Approval will be granted if prescriber meets the qualification criteria under Drug Additional Treatment Act (DATA) of 2000 and has been issued a unique DEA identification number by the DEA, indicating that he or she is qualified under the DATA to prescribe Subutex or Suboxone **AND** The client has a diagnosis of opioid dependence **AND** The client is 16 years of age or older **AND** No claims data show concomitant use of opiates in the preceding 30 days **AND** The client must have tried and failed, intolerant to, or has a contraindication to generic buprenorphine/naloxone SL tablets.	One year